

that Prof. Barker has exerted upon them the charm of his personal magnetism to develop such enthusiasm and self-forgetfulness in the laborious study and faithful delineation of the symptoms in each case. A few statistical tables in regard to the frequency and distribution of the cases during the last epidemic of puerperal fever are added as an appendix to this valuable work, with regard to which there can be but one opinion. No one can read it without profit; the general practitioner will find in each chapter valuable practical suggestions in regard to the dietetic care of the patients, by which puerperal disease may be averted, or clear, concise statements of those methods of treatment which have proved most serviceable in a hospital experience of twenty years and an extensive private practice. He who would gladly pass beyond the mere performance of routine duties and acquaint himself more intimately with the character of the morbid processes of the puerperal state, were it not that the necessary time for such study is wanting, or that the facts are inaccessible because hidden in a foreign tongue, will find in this work a *resumé* of those theories which at present claim the attention of the most prominent workers in this branch of medicine; while no one will, we are assured, find more enjoyment in this volume than those who have made obstetrics the subject of especial study; for the judiciously selected clinical cases, and the expression of the matured views of one whose scattered writings have long been sedulously gathered together and preserved, will surely receive from them the most attentive consideration. To each one individually the volume thus appeals, while the fluent, graceful style, the apt illustration, the earnest spirit of investigation which pervades the whole work, will commend it to all. Such contributions as this, and the Clinic of the late Prof. Elliott, which represent the fruit of years of patient and laborious hospital service, are well fitted alike to stimulate others to generous rivalry in this field and to advance the interests of obstetric science.

W. F. J.

ART. XXII.—*A Clinical History of the Medical and Surgical Diseases of Women.* By ROBERT BARNES, M.D. Lond., Fellow and Lumleian Lecturer (1873) Royal College of Physicians; Examiner in Obstetrics and the Diseases of Women at the University of London and the Royal College of Surgeons; Obstetric Physician and Lecturer on Obstetrics and the Diseases of Women to St. Thomas's Hospital. With one hundred and sixty-nine illustrations. 8vo. pp. 792. Philadelphia: Henry C. Lea.

THIS work, issued in London in November last, and republished in this country in February, will, we believe, meet with a most cordial reception. Embodying the long experience and personal observation of one of the greatest of living teachers in diseases of women, it seems pervaded by the presence of the author, who speaks directly to the reader, and speaks too as one having authority.

And yet, notwithstanding this distinct personality, there is nothing narrow as to time, place, or individuals in the views presented and in the instructions given; Dr. Barnes has been an attentive student, not only of European, but also of American literature pertaining to diseases of

females, and enriched his own experience by treasures thence gathered; he seems as familiar, for example, with the writings of Sims, Emmet, Thomas, and Peaslee, as if these eminent men were his countrymen and colleagues, and gives them a credit which must be gratifying to every American physician.

The philosophic spirit which characterizes the volume is worthy of note. It manifests not only the broad outlook to which we have already alluded, not only painstaking and conscientious investigation, but completeness of classification, clearness of order, a love of unity, and faithful efforts to trace phenomena to their appropriate causes.

A negative merit of the work is that no hobby-riding is manifested, unless it be, as some will judge, in the too great extension given to *mechanical dysmenorrhœa*. Guizot has stated, we think, that every man profoundly impressed with the truth of an idea, becomes a missionary of that idea. Unfortunately for the progress of uterine pathology, unfortunately for the progress of uterine therapeutics too, begetting exclusiveness in each, we have had missionaries of particular ideas in the literature of diseases of women; each so intent upon his own peculiar theory, that he lost sight of much, possibly of most, of the territory of truth lying quite without his own special domain. But Dr. Barnes does not seem under the dominion of any pet theory. He has produced a representative work, not only representative of his individual views and experience, but also representative of the present condition of uterine pathology and therapeutics.

Terminating these general observations, we propose now an examination of the work, not in all, but in many of its parts, presenting in the course of this examination alike subjects of hearty approval, and some few of hesitating dissent—hesitating, because agreement is always pleasanter than difference, and because disposed to distrust our own opinions rather than those of one so able as Dr. Barnes.

In his preface, the author states a truth familiar enough to intelligent physicians, but not so clearly recognized in society in its systems of education and modes of work and manners of living as it should be: "in the woman, the reproductive organs exert a vastly greater influence than they do in the man."

Another remark quoted from the preface—it is made in apology for the extent of the work—may remind us of the imperfect condition of gynecological science and art, moderating our pride with the reflection that much of our present knowledge is merely provisional, only scaffolding for the final edifice, nothing but stepping-stones over which we walk to a broader way, and to the attainment of a larger view. "In a subject of comparatively recent inquiry, necessarily, to some extent, unsettled and open to controversy, a fuller statement of fundamental facts and more argumentative discussion, are called for than are necessary in the more generally cultivated departments of medicine."

The first five chapters contain a very good, though, of course, brief description of the anatomy of the genital organs, and include twenty-six excellent illustrations, some of them new in a text-book on diseases of women.

The sixth chapter considers the *conditions indicating necessity for examination*. In the course of this chapter the author introduces into medical language the word *dyspareunia* to express the condition of difficult or painful performance of the sexual function; he regards this

word as expressive, euphonious, and in harmony with medical language. Now, with all deference for Dr. Barnes's classical attainments, as well as for those of his colleague for which he vouches, and who was the consultant at the birth of this, as we believe, abnormal and needless word, we venture upon a criticism.

Let Dr. Barnes invent a speculum, an ovariectomy clamp, or even a pessary, and the profession—sorely in need of such invention—will be profoundly grateful, but let him not lay upon our lexicographers the burden of dyspareunia! Already this word appears in the last edition of "Dunglison," but we hope it will be absent from the next.

Dyspareunia is a word for which we do not see the necessity, of which we cannot discover the fitness. We have *Dyssynodus* and *Dyssynusia*, Dunglison, *Dyssynusie*, Dictionary of the French Academy, the derivation being from *δυσ*, *difficult*, and *συνωδος*, or *συνουσία*, *coition*. Either of these words, it seems to us, expresses the very idea Dr. Barnes wishes to convey, and therefore, we think a new word unnecessary. Moreover, the term Dr. Barnes proposes is expressive of a moral, not of a physical difficulty. We have examined three of the Plays of Sophocles in our search for *δυσπαρευνος* (Dr. Barnes stating that the Greek poet used the word with the signification which he has given dyspareunia), and we have found it once: it occurs in the following passage from the *Trachiniæ*.

Το δυσπαρευνον λείπτρον ενδατουμενος
σου της τάλαινης, etc.

These words, as rendered in the Oxford translation, are "reviling the evil nuptials of your unhappy couch;" they occur in the description of the conduct of Hercules after he had put on the fatal gift sent him by his wife, Dejanira, who was jealous of the love of her heroic husband, but innocent of any desire to injure him, and had been deceived by the dying centaur: Dejanira too had borne children to Hercules; proving most conclusively that she had not been at least seriously affected with vaginismus, or any other form of dyspareunia, as Dr. Barnes uses the word.

The seventh chapter is upon the *significance of leucorrhœa*; and then follow chapters upon *discharges of air, watery discharges, purulent discharges, hemorrhage, pain, dyspareunia, and sterility*.

One of the best of these is upon *hemorrhage*; coupled with a consideration of the significance of this symptom is a brief but excellent summary of its therapeutics. Dr. Barnes believes the following to be the most valuable and generally applicable rule: *In all cases of hemorrhage coming from the body of the uterus, obtain and maintain free patency of the cervical canal*. He refers to the dangers from intra-uterine injections when the cervical canal is contracted, and remarks that dilatation is often sufficient to arrest the flow, and at any rate, once accomplished it facilitates the application of a styptic directly to the bleeding surface. And yet is it not the means used to dilate with—sponge or sea-tangle tents, a temporary uterine tampon—that in some instances, at least, stops the hemorrhage? The remedies recommended by Dr. Barnes for internal use are ergot, digitalis, cinchona, turpentine, ipecacuanha, acetate of lead, tannin, alum, dilute sulphuric acid. Nevertheless, we believe most practitioners find themselves disappointed by astringents internally administered, in the treatment of menorrhagia, or of metrorrhagia; occasionally the flow may be arrested under the use of one or of another of this class of agents, but they fail so often that one grows sceptical as to their beneficial results. There are two remedies, however, which, in our opinion, are of signal value,

the one in the treatment of menorrhagia, the other in metrorrhagia consequent upon fibroid disease; these agents are quinia and ergot. Of the latter we shall speak again when we refer to Dr. Barnes's treatment of fibroid tumours of the uterus; as to the former there is good reason to believe, as Dr. Bartharez¹ has said, that some forms of uterine hemorrhage are subdued by sulphate of quinia, and hence this medicine has, in addition to the remarkable properties heretofore recognized in it, the not less extraordinary power of acting directly upon the vaso-motor nerves, as well as upon the uterine fibres in determining their contraction.

The chapter devoted to *pain* occupies but four pages. A similar discussion in Courty² is ten pages in length, and we think is more satisfactory than that which Dr. Barnes has given. We wish especially that our author had devoted some space to the therapeutics of pain as he has to those of hemorrhage; each it is true is a symptom only, nevertheless a symptom the immediate relief of which is often a prime necessity. We believe Sir Benjamin Brodie, in the terrible suffering which terminated his life, uttered the earnest wish that physicians would study pain more, and the means for its relief.

Again, let us say, we should be glad had Dr. Barnes thrown the helpful light of his large experience upon the treatment of pain as it occurs in diseases of women.

In the fifteenth chapter we have presented *the instruments for diagnosis and treatment*. Dr. Barnes regards Neugebauer's speculum, which is at once a bi-valve and double duck-bill, as the best for hospital use. He refers to the *endoscope*, not Desormeaux's, as one might imagine, but Jobert's and Tyler Smith's: he does not give the relative nor the absolute value.

The seventeenth chapter discusses *menstruation*. This phenomenon, or rather this association of phenomena, is so important as typical of certain morbid uterine conditions, as frequently the commencement, or as revealing positive diseases, either hitherto dormant, or at other times hidden, that its clear presentation is eminently suitable before investigating those conditions and diseases. So, too, Dr. Barnes does not pursue the usual order of systematic treatises on diseases of women, but follows disorders of menstruation with diseases of the ovaries, an innovation worthy of the best approval, since such order is in accordance with physiology. M. Pajot³ remarks, *Propter solum uterum*, etc., *cette vieillesse de Van Helmont*, was tolerable when physiologists attributed menstruation to the moon, but is false in every respect.

Not even the adoption of a portion of this effete dogma as a motto by so learned a body as the Boston Gynæcological Society, still less the further meaningless abbreviation of it into *uterum mulier est*, by a recent American writer,⁴ for which he deserves to be haunted by the ghost of Van Helmont, or else there is no use for ghosts—can rescue it from utter oblivion.

In the chapter upon menstruation, Dr. Barnes describes *vicarious*,⁵ or as he prefers to call it *ectopic*, menstruation. Since we have already two

¹ Du Traitement des Hemorrhagies de Matrice, par le Sulfate de Quinine. Paris, 1872

² Traité Pratique des Maladies de l'Uterus, etc. Second edition. Paris, 1870.

³ Archives Générales, vol. i. 1867.

⁴ Vide Report of Columbia Hospital.

⁵ Raciborski, Traité de la Menstruation, regards this disorder as a *neurosis*, and designates it *menstrual stasis*.

words, *menoxenia*¹ and *menoplasia*, either of which expresses the idea sought to be conveyed, and is so defined by the best lexicographers, would it not be better to use one of them?

The mental disturbances of menstruation which occur in many cases are thus set forth by the author:—

"Perception, or at least the faculty of rightly interpreting perception, is disordered. Excitement to the point of passing delirium is not uncommon. Irritability of temper, disposition to distort the most ordinary and best meaning acts or words of surrounding persons, afflict the patient, who is conscious of her unreason, and perplex her friends, until they have learned to understand these recurring outbursts. Despondency to the verge of melancholy, violence to the verge of mania, impulse ungovernable to the verge of monomania, false ideas, distorted judgment to the verge of delirium, and sometimes overstepping the boundary, render the sufferer for a time irresponsible. Lunatic asylums offer numerous examples of comparative abeyance of the usual manifestations of insanity during the intermenstrual periods, and of their exacerbations when the catamenia returns. Not even the best educated women are all free from these mental disorders. Indeed, the more predominant the nervous element, the greater is the liability to the invasion. Women of coarser mould, who labour with their hands, especially in outdoor occupations, are far less subject to these nervous complications. If they are less frequently observed; if they less frequently drive refined women to acts of flagrant extravagance, it is because education lends strength to the innate sense of decorum, and enables them to control their dangerous thoughts, or to conceal them until they have passed away." (pp. 161-2.)

Brierre de Boismont has shown that for one-fifth of females, the menstrual period is a time of suffering and manifestation of various disorders—neuralgia, hysteria, epilepsy, mental derangement: probably this proportion is too small rather than too great.

In several forms of monomania it has been observed that the commission of crime was coincident with menstruation. But, as a rule, the severe forms of mental disorder are connected with amenorrhœa and dysmenorrhœa; thus, in more than a hundred cases of such disorders, ranging from simple intense nervous excitement through various grades up to positive dementia, which Berthier² has collected, the great majority were in direct relation with one or the other form of menstrual derangement mentioned.

The eighteenth and nineteenth chapters are devoted to *amenorrhœa*: the first to that form of the disorder in which no exterior flow occurs, because no hemorrhage takes place from the lining membrane of the womb—this form, embracing two varieties, *primitive*, and *accidental*, or *secondary*—and the other to *amenorrhœa from retention*, as generally designated, but which Dr. Barnes prefers to designate as *concealed* or *occult menstruation*.

In discussing the treatment of *primitive amenorrhœa*, the author refers to Golding Bird and Duchenne advising electricity, but does not himself speak very favourably of this remedy. We find in Dr. Clarke's well-known work,³ the third edition of which was published in London in 1831,

¹ Duglison, indeed, defines this word as irregular menstruation: true it is irregular in a restricted sense; the etymology closely points to what we generally understand by vicarious menstruation, and thus it is defined by Littré and Robin (*Dictionnaire de Médecine, de Chirurgie, etc.*, Paris, 1873).

² *Des Neuroses Menstruelles, ou La Menstruation dans ses Rapports avec les Maladies Nerveuses et Mentales.* By Doctor Berthier, Paris, 1874.

³ *Observations on those Diseases of Women which are attended by Discharges.* By Sir Charles Mansfield Clarke.

the following earlier testimony to the value of electricity: "A great number of cases of amenorrhœa have been cured by electricity, when no other means have been successful."

Dr. Barnes states that "the most effectual remedy is probably the galvanic pessary of Simpson." The cases probably in which this instrument is most efficient, are those where the uterus has not attained its complete development, *uterus infantilis*. But as a rule, the instrument, as usually found in our shops, has too long a stem to be safely used in such a condition; the stem ought not in these cases in general to be more than an inch and a quarter for it to reach the fundus of the uterus when the treatment is commenced. Another matter of practical importance to be mentioned, is the protracted time required for the wearing of the pessary—frequently a cure will not be effected for months. And during these months it may be necessary occasionally to remove the instrument; it will be necessary so to do at the least threatening of uterine or of pelvic inflammation. While writing this review, we have noticed the report¹ of a recent discussion in the London Obstetrical Society upon the danger of "intra-uterine stems," and one of the speakers, Dr. Savage, stated that seven fatal cases had been brought under his notice; and while it is probable all these were cases where the stems were worn for the relief of a flexion, and while the undeveloped uterus is much more tolerant of a foreign body than is one fully developed and distorted, yet we cannot be too cautious even in the former case, lest our means of attempted cure should prove a serious, or even fatal injury.

Dr. Barnes remarks, that "Amenorrhœa, especially if attended by marked chloro-anæmia, is very liable to merge into or induce pulmonary consumption."

Every statement of this kind, coming from such an authority, is worthy to be well considered by the profession. Nevertheless, as a counter-statement, we must be permitted to introduce the testimony of Raciborski, "in the patients we have seen phthisis was never the effect, but always the cause of the amenorrhœa."

In regard to amenorrhœa from retention, Dr. Barnes justly remarks, that in its practical bearings it will be found naturally to take its place between amenorrhœa and dysmenorrhœa. A somewhat similar observation is made by Bernutz,² who, speaking of the two varieties of amenorrhœa, similarly characterized by the exterior absence of the flow, nevertheless are too dissimilar in their etiology, in their symptoms, in their consequences, and in their therapeutics, to be united in a common description, suggests that it would be a real advance to entirely separate vices of secretion from those of excretion, connecting the latter with dysmenorrhœa.

The *atresia* which precludes the exterior flow of the monthly hemorrhage may be congenital or accidental. Dr. Barnes remarks that "the congenital condition consists in abnormal formation from imperfect or defective or excessive development." On the other hand, Courty³ states, that congenital atresias, whatever their situation or extent, are due to an arrest of development. Let the student of embryology reconcile the two statements, or take which one he prefers.

A point of considerable practical interest in reference to cases of menstrual retention, is how soon a fatal termination may be expected if

¹ The Lancet, Jan. 31st, 1874.

² Nouveau Dictionnaire de Médecine et de Chirurgie Pratiques, vol. ii.

³ Traité Pratique Maladies de l'Uterus, etc., 2d ed., Paris, 1870.

the obstruction is not removed. Bernutz, *op. cit.*, states that in congenital retention, a fatal result does not usually occur before the second or third year, and that Hervez de Chegoin had reported a case in which ten years had elapsed without its taking place; he also says that in acquired retention there is a much greater gravity in the earlier symptoms, often at the very first period presenting as serious disorder as is observed at the fifth or sixth month of congenital retention. But in this very work Dr. Barnes reports a case of acquired atresia of twelve years' standing upon which he operated. A year ago, the writer operated on a case where the uterus was completely closed as well as the upper half of the vagina, the closure resulting from inflammation following the patient's first and only parturition seventeen years before.

As to the treatment of cases of menstrual retention, the principle is obvious, to give exit to the accumulated fluid. And yet even in cases where the obstruction is simply an imperforate hymen, the operation may be followed by death; thus two fatal results occurred in one hundred and thirty-five cases. Still more. In twenty-six cases of congenital atresia of the vagina successfully operated on, there were six deaths, and in twenty-five cases of accidental atresia, about the same mortality; in atresia, congenital or acquired, of the neck of the womb, one death in about thirteen.

What precaution should be taken to prevent a fatal result consequent upon the operation? Of course one of the great dangers is escape into the peritoneal cavity of a portion of the menstrual fluid, and inflammation resulting therefrom. Upon this point Dr. Barnes remarks as follows:—

"It has frequently been discussed how the catastrophe of sudden escape of the retained fluid into the peritoneal cavity may best be averted. Some have contended that it is better to make a very small opening in the hymen¹ and let the fluid drain away gradually, hoping that in this way the suddenness of the collapse of the uterus might be diminished. This is the plan I have hitherto followed. But others have preferred making a free incision at once, and even proceeding to wash out the cavity. I am not sure that this is not the best plan. A free external outlet would make it easier for the contracting uterus to expel its contents by this route, and thus take off the pressure toward the tubes. On the other hand, the rapid retreat of the uterus would favour laceration of the tubes, if held back by adhesion. The balance of advantages and of drawbacks of either plan is difficult to strike; and it is to be apprehended that cases will continue to occur in which a fatal result will follow any method of treatment." (pp. 189-190.)

Spencer Wells has remarked,² "Further observation is required to teach us whether in cases of menstrual retention, it is better simply to remove the obstruction, and leave the fluid to escape gradually, or to press it all away and wash out the cavity by iodine injections."

Mr. Craddock³ has reported a case of vaginal occlusion of some months' standing successfully treated, where, after making an exit for the pent-up fluid, pressure was applied above the pubes until the uterus could no longer be felt. On the other hand, Bernutz⁴ is very positive in forbidding any pressure upon the abdomen, citing a case from Locatelli where such pressure seemed to be the cause of rupture of the Fallopian tube, and consequent intra-peritoneal effusion followed by fatal peritonitis; he advises

¹ Dr. Barnes says hymen, but we imagine he includes other obstructions as well.

² Transactions of Obstetrical Society, vol. xii.

³ *Ibid.*, vol. xiii.

⁴ Clinique Médicale sur les Maladies des Femmes, vol. i. pp. 302, 303.

puncture of the obstruction with a small trocar, such as is used for hydrocele, avoiding a rapid emptying of the uterus with consequent abrupt retraction of this organ, and resulting contractions of the tubes which are especially to be dreaded: he objects to a canula being left in the puncture—Court, *op. cit.*, advises it—but instead of it would resort to subsequent punctures, until the greater part of the uterine contents was evacuated, and not until then would freely divide the obstruction.

In an eloquent address delivered by Dr. Barnes at the London Hospital some thirteen years ago, he advised his students when they found authorities differing, not to engage in controversy, but to humbly and patiently question nature and appeal to her testimony. The advice is pertinent to the present topic.

The twentieth, twenty-first, and twenty-second chapters are occupied with the different forms of *dysmenorrhœa*.

We have already alluded to the important position which Dr. Barnes assigns mechanical *dysmenorrhœa*. He says (p. 201), "that in a very large proportion of cases of *dysmenorrhœa*, some distinct mechanical anomaly of the uterus will be found." Contraction of the external os especially is one of the most frequent and important factors in the production of *dysmenorrhœa*. To remove this he is a warm advocate for incision, and for incision rather than dilatation. Certainly the therapeutic problem of this most capricious, painful, and most obstinate of disorders is greatly simplified if the views of Dr. Barnes as to its etiology are correct. Spencer Wells seems to fully endorse them in the following language—he "believed a very large proportion of cases of true *dysmenorrhœa* depend upon mechanical impediment to the free escape of the menstrual fluid, and are curable by removal of the obstruction." On the other hand, they are not sustained by such authorities as Playfair, Snow Beck, Royers, and Tilt.

It would wonderfully advance the general acceptance by the profession of the mechanical theory of *dysmenorrhœa*, if there were agreement on the part of those who advocate division of the cervix, as to the seat of stricture.¹ Not to transfer the subject outside the great world of London, we see eminent men there taking opposite sides as to a simple fact. Indeed, it strikes one as wonderful, almost inexplicable, that the women, *dysmenorrhœic* and sterile, who have contraction of the internal os, consult Dr. Greenhalgh, for example, since, in 1866, he stated he had operated on nearly three hundred cases,² the seat of stricture being in the great majority the internal os,³ which had to be freely divided. And, on the other hand, they are very shy of Dr. Rasch, who has passed the sound in between three thousand and four thousand cases, and has never yet found stricture of the internal os. But the patients having *dysmenorrhœa* and sterility, with obstruction at the os externum, find their way to Dr. Barnes.

Although adopting the opinion of Dr. Barnes rather than that of Dr. Greenhalgh—that is, that the stricture is at the external rather than at the internal os—the utter disagreement of two such eminent men, and of others equally celebrated, upon a condition apparently so simple, and

¹ Obstetrical Transactions, vol. xiv.

² *Ibid.*, vol. viii.

³ In the *Lancet*, Jan. 10, 1874, the writer of a review of "Barnes" states that "in a large number, if not the majority, of the cases in which we have felt called upon to operate for the cure of this obstruction, the stricture has been at the internal os."

the truth in reference to which it would seem might be settled beyond cavil, reminds one in some points of the story from Helvetius, related by Sir Wm. Hamilton, in his Lectures on Metaphysics: "A gay lady and a parson, hearing that the moon is peopled, are examining the orb with a telescope. The lady, looking first, perceived two shadows bending towards each other, which she doubted not were happy lovers; but the clergyman then looks, and assures her they are not lovers at all, but the steeples of a cathedral. This story is the history of man. In general, we perceive in things only what we are desirous of finding: on the earth, as in the moon, various prepossessions make us always recognize either lovers or cathedrals."

Inflammatory dysmenorrhœa and *dysmenorrhœa membranacea* are the subjects of the twenty-second chapter. In regard to the latter form, Dr. Barnes, while stating that the greater number of membranous structures discharged in dysmenorrhœal cases occurred in married women and with delayed menstruation, recognizes the possibility of the discharge of a dysmenorrhœal membrane by virgins. He evidently does not give so great an extension to membranous dysmenorrhœa as did Dr. Dewees,¹ who states that he cured more than a hundred cases with the tincture of guaiacum; not even as great as Huchard and Labadie-Lagrave, who have tabulated twenty-eight cases in the last part² of their interesting memoir upon the subject, nor does he speak as unequivocally of its being a result of inflammation, an endometritis, as the two writers just mentioned, or Raciborski, Bernutz, Tilt, and Gallard do; nor does he mention in the treatment either incision or dilatation of the cervical canal, means which would greatly facilitate the otherwise tedious and painful expulsion of the membrane from the uterine cavity, and one of which—dilatation—has proved so effectual in the hands of Siredey³ in curing a case of this disease.

After chapters devoted respectively to *menstrual irregularities of the climacteric epoch*, *the relations of menstruation to various diseases*, and *the disorders of senility*, there are eight chapters given to *diseases of the ovary*, one each to those of the *Fallopian tubes* and of the *broad ligaments*, and to *extra-uterine gestation*. Time does not permit our noticing these chapters in detail; even that most interesting portion of them devoted to cystic tumours of the ovary, and ovariectomy, we must pass by with only two or three brief references—an omission that we less regret since the valuable volumes of Peaslee, Atlee, and Wells have so recently been issued, and have been fully reviewed in this Journal.

Dr. Barnes states (p. 321), in reference to the diagnosis of adhesions: "If we can make out a thin layer of ascitic fluid, giving a wave superficial to the tumour, we have, perhaps, the best evidence of absence of adhesions." Yes: absence of anterior abdominal, but not of lateral, of posterior, nor of pelvic adhesions.

In speaking of tapping, Dr. Barnes states (p. 330), "a considerable proportion of patients die very quickly after its performance." He also gives some statistics as to the mortality after this operation, but adds that he thinks that these figures give an exaggerated idea of the danger, and finally says that tapping is attended with considerable risk. Let us thank him, however, for stating that in many cases it may be regarded as a valuable

¹ Diseases of Women, ninth edition, p. 129.

² Archives Générales, April, 1872.

³ Nouveau Dictionnaire de Médecine et de Chirurgie Pratiques, vol. xii.

auxiliary to extirpation, giving means for more accurate diagnosis, and giving time for the patient to recruit her general health, by relief from the pressure before the extirpation is undertaken. We believe another excellent reason may be adduced for a preliminary tapping, viz., the extirpation can be performed while the tumour is still small; it is less violence to remove ten or twenty pounds than fifty or sixty.

But does not Dr. Barnes state too strongly the danger from tapping? The writer's experience is small; nevertheless, as far as it goes, it gives a decided answer in the affirmative to this question. He has now under his charge a patient, unwilling to have ovariectomy performed, who has been tapped five times; twice he has performed ovariectomy where the patients had been tapped once, once where the patient had been tapped twice, and once where seventeen tapplings had preceded the operation. His observation furnishes him with six other cases where the operator previously tapped the patients, and there was not one fatal case.

On page 336, it is stated that "it is mainly to the enterprise and skill of British surgeons ovariectomy has attained its present position. Up to this day the operations in Great Britain alone form a very large proportion, if not a majority, of the total." As to the former statement opinions might differ, and, as Dr. Johnson has said, "in the arena of conjecture all men are equal whose opportunities for information are equal." But as to the latter, certainly Dr. Barnes is mistaken in suggesting that probably a majority of the entire number of ovariectomies have been performed in Great Britain: this is a matter of fact, not of opinion; it was not true at the time Dr. Peaslee's¹ work was written, and we know no more recent statistics to appeal to. Dr. Peaslee credits Great Britain with between ten and eleven hundred; the United States with seven hundred and thirty-nine; France, one hundred and ninety;² Germany, one hundred and eighty, making a total of over eleven hundred for these three countries, against less than that number for Great Britain. If we were to add to the eleven hundred, operations performed in Italy, Russia, Sweden, etc., the "actual majority" would of course be still more decidedly against Dr. Barnes's supposition.

The thirty-seventh chapter includes *general observations in uterine pathology; effects of labour and lactation; involution in defect and excess.*

The following extract is as admirable and condensed an argument in favour of the mother suckling her infant as could well be made:—

"The most healthy stimulus to uterine involution is the natural function of lactation. If this duty—this physiological complement to parturition—be neglected, involution will not go on smoothly. The application of the infant to the breast causes contraction of the organ. It is injurious to lose this. Lactation, moreover, causes a derivation to a distant organ, tends to promote rest in the pelvis. Indeed, one of the beneficent purposes of this alternative or cyclical action of the generative organs, is to give each in its turn the rest that is necessary for restoration. This natural order cannot be broken with impunity. The penalty, or rather one of the penalties, of suppressing the function of the breasts, by depriving the uterus and ovaries of their allotted respite, is the resumption of work before they have had time or opportunity to recover their fitness for the task." (p. 412.)

¹ Ovarian Tumours, New York, 1872.

² Since writing the above we find that the number of ovariectomies performed in France up to January 1, 1870, was two hundred and twenty-three. (Vide Dr. Louis Galliez's work entitled *Histoire des Kystes de l'Ovaire*, etc. Brussels, 1873.)

The testimony of physicians is unanimous as to the injurious consequences to the mother of her not nursing her infant. But one of the most striking facts in reference to this matter is found in the statistics of Aran—out of a hundred patients with uterine disease, seventy had not nursed.

Dr. Barnes states that he is disposed to fix the normal period for complete uterine involution—the person being in health and in favourable circumstances—at one month. Schröder¹ regards it as about six weeks, and this view is more nearly in accordance with the researches of Wieland, Hecker, and Heschl.

The injurious effects of over-lactation, not only upon the general health but upon the uterus, are fully presented; and in the constitutional treatment advised by Dr. Barnes, we are glad to see quinia directed, not only as a tonic, but also for its property of causing contraction of the uterine fibre, thus promoting involution, the diminution of congestion and of the tendency to metrorrhagia.

The whole chapter is marked with a clear exposition of deranged conditions, their symptoms and causes, and eminently practical and useful directions for their treatment.

The latter part of the chapter presents the *results of injury to cervix uteri during labour*, and in this presentation the topics of inflammation and ulceration—sometimes fruitful sources of tedious and useless logomachies—occupy due prominence.

The thirty-ninth chapter, entitled *conditions marked by altered vascularity or blood supply; fluxion; hyperæmia; congestion; inflammation*, launches us upon a troubled sea of conflicting definitions and of discordant opinions—the conflict and discord being not so much in Dr. Barnes's views (though we confess to following him some of the time more by faith than by sight, and we are not quite willing to admit that the apparent darkness of the way arises altogether from our own defective vision), as in the opposition they have to those of other authorities. There is an authority, however, with whom Dr. Barnes is almost completely in accord in the chief topics presented in this chapter—Courty; and the fact that there is this striking coincidence of opinion between these two eminent men—and the literature of diseases of women presents no two abler teachers—is a strong argument in favour of the scientific truth and of the practical value of their views. But let us briefly present these views. *Fluxion*, according to Dr. Barnes, in its simplest form is a transitory flow of blood to a part. Uterine fluxion may take place under the stimulus of the child's nursing (some will put an interrogation point after the statement just made, saying that this stimulus, when it causes excitement, ordinarily excites pain, contraction of the uterus, diminishes blood supply to it, etc.), under the influence of various emotions, as the sexual passion: "this fluxion, of course, is perfectly physiological;" so, too, the fluxion determined by ovulation.

The developmental attractions of pregnancy furnish an example of fluxion; so, too, the developmental attraction of fibroid tumours, but in the former "the fluxion is more uniformly persistent;" "it is a steadily maintained active hyperæmia;" but there is "a persistent hyperæmia" in the other case.

Dr. Barnes quotes from Billroth—the passage has already done duty in "Courty"—a description of the phenomena of fluxion, the quotation

¹ Manual of Midwifery.

terminating, in Dr. B., with the familiar axiom—*ubi stimulus ibi fluxus*. Certainly; and to sum up the whole matter, as it seems to most minds, the irritation is the disease, not the fluxion; a physiological fluxion of course, too, is normal, not morbid; and a pathological fluxion is nothing save as an indication of some local irritation, or as inducing hyperæmia or congestion—words that we believe should be used as synonymous, since such is their use by most writers.

Courty's definition of *uterine fluxion* embraces blood movement to the uterus, indicated by symptoms analogous to, but much greater than, those which indicate the advent of menstruation in some women; but for him there is likewise a *chronic fluxion*: this Dr. Barnes rejects, though, as we have seen a moment ago, that fluxion, which is "a persistent hyperæmia," cannot differ very widely from a chronic disorder. Courty says that where chronic fluxion exists there is always congestion, often engorgement, and hypertrophy of the organ.

Now let us pass on to *hyperæmia*, the *hyperæmia* of Dr. Barnes, the *congestion* of Courty.

Hyperæmia, says the former, is a continuous or chronic fulness of the vessels of a part, which does not necessarily imply morbid action in that part, but which at most leads to languid, passive changes. It occurs especially in connection with excessive menstrual congestion; it may occur in heart disease, in flexion or other displacements of the uterus; new formations may cause and keep up hyperæmia; "persisting hyperæmia" leads to "persistent secretion of mucus," to general or partial hypertrophy, disposes to œdema of the tissues and to hemorrhage, or may increase the connective tissue, thus occasioning induration or *infarctus*.

Courty defines uterine *congestions* as fulness of the bloodvessels of the uterus—uterine plethora; it results from simple fluxions very active or often repeated, or from impediment in the general or local circulation, and also from excessive menstrual determination of blood with insufficient flow; it may produce leucorrhœa, general or limited hypertrophies, and hemorrhages.

Congestion or engorgement, Dr. Barnes says, is a more prolonged fulness of the vessels than mere fluxion; it rarely exists without some retardation of the blood in the vessels, that is hyperæmia; and this retardation almost certainly¹ entails more or less effusion of the serous or aqueous elements of the blood into the tissues of the organ affected.

The symptoms of congestion "are essentially the same as those which mark the combination of fluxion and hyperæmia."

Engorgement of the uterus, according to Courty, is a persistent tumefaction of this organ caused by infiltration of its normal anatomical elements by amorphous material, either liquid or semi-liquid. And, indeed, thus *engorgement* is generally understood; it is so defined by Littré and Robin, *op. cit.*, and several other authorities, though, on the other hand, Luton speaks of hyperæmia² of several of the abdominal viscera being termed engorgements, and, still further, Becquerel and some others have made it a synonyme of inflammation, dividing it into acute and chronic, just as Dr.

¹ "Almost certainly" here, but a few sentences further on all doubt ceases. "The organ in which it"—i. e., congestion—"occurs is rendered permanently larger, its tissues are infiltrated with serous or semi-plastic extravasation," etc., a description, by the way, which corresponds exactly with Courty's definition of *engorgement*.

² Nouveau Dictionnaire de Médecine et de Chirurgie Pratiques, ninth volume—article, *Congestion*.

Barnes makes or seems to make it, a synonyme of congestion. We believe Dr. Barnes's congestion is either hyperæmia or engorgement; these two conditions approximate so closely that there is no space for a third to be interposed.

Are not hyperæmia and congestion generally used synonymously? Klob¹ makes hyperæmia of the uterus the same as congestion, and speaks of it as either active, *fluxion*, or passive, that is, caused by impeded venous reflux, or as Luton, *op. cit.*, expresses it in general, *congestion from accommodation, congestion from retention*. The word *hyperæmia*² was suggested by Andral, etymologically more expressive than congestion, as the opposite of anæmia, and simply meaning accumulation of blood in the vessels of a part or organ. Nonat considers hyperæmia as synonymous with congestion, and states that it is unnecessary to make two pathological conditions of fluxion and congestion, the former being but the initial phenomenon, the first stage of a more complex morbid act, congestion.

Gallard³ thus refers to "a disease sometimes called *fluxion*, sometimes *active congestion of the uterus*." He goes still further, saying—

"The line of demarcation between congestion and inflammation it is impossible to define, and in this respect uterine pathology is no exception to the common rule, for in pneumonia, for example, we experience the same difficulty of declaring where congestion ends, where true inflammation begins. Congestion and the first stage of inflammation are one and the same pathological condition."

Pajot, in the course of an able review⁴ of the first edition of Courty's work, in discussing the author's teaching as to fluxion and congestion, remarks that if the former is fulness of the vascular system of the uterus, and if the latter is the determination of blood to the uterus, the principal fact is a larger quantity of blood in the organ, it will be conceded one can scarcely occur without the other. Fluxion is a temporary congestion, while congestion is a permanent fluxion.

And now, to conclude the discussion of these topics, we believe that plain, practical physicians, unversed in the terminology of teachers, unskilled in the theoretical niceties of pathology, will continue to recognize uterine congestion, or hyperæmia, as active or passive, and treat it accordingly, that fluxion will appear to them simply the *mode* in which one form of congestion is produced, the fluxion itself generally a consequence of some local irritation, that engorgement is one of the *forms*, and inflammation is the *result*, though not inevitable, of congestion.

The fortieth chapter conducts us through the various forms of uterine inflammation, *metritis*, *acute* and *chronic*, *endometritis*, etc. We are compelled to dismiss this excellent section with only two or three observations.

On page 455, Dr. Barnes says :—

"Certain considerations, however, incline me to think that the reaction against Bennett's too exclusive limitations of inflammation to the cervix has been carried too far: 1. In a large number of cases treatment directed solely to the os and cervix cures all the disease."

Other considerations are then mentioned. But is this argument a good

¹ Pathological Anatomy of the Female Sexual Organs.

² *Traité Pratique Maladies de l'Uterus*, etc., 2d edition, Nonat and Linas. Paris, 1870.

³ *Leçons Clinique sur les Maladies des Femmes*. Paris, 1873.

⁴ *Archives Générales*, vol. i. 1867.

one? Must we always direct our remedies solely to a diseased organ or to a diseased part of it to accomplish a cure? On p. 458, Dr. Barnes states that counter-irritants applied to one part of a diseased structure may, by derivation, or by setting up healthy nutrition in contiguous parts, cure the whole diseased organ. But it is also true that counter-irritants applied to a healthy part of an organ may by derivation cure a diseased part.

Dr. Barnes occupies several pages in the consideration of intra-uterine injections, his general conclusion being to restrict them within the narrowest limits.

"I rarely employ them now except in cases of urgent danger from metrorrhagia. We may obtain almost all the advantages that injections are capable of giving by other means. For example, the same agents which are so useful in the form of solution for injections, may be applied either by swabbing, or solid, or in the form of ointment." (p. 468.)

He regards sulphate of zinc in substance as one of the most widely useful topical applications to the mucous membrane of the cervix and body of the uterus—safer than nitrate of silver, almost equally useful; it is applied as a solid stick of two or three grains by means of a canula and stylet, which Dr. Barnes has devised for this and similar uses.

"A most precious way of applying astringents, caustics, solvents, or alteratives to the interior of the uterus is in the form of ointment or pasma. In this way almost any substance may be applied. Where grease is objectionable as a vehicle, a pasma of suitable consistence may be made by glycerine or other substances." (p. 469.)

Whereupon we remark that after some experience in the intra-uterine application of ointments by Dr. Lente's instrument, we came to the conclusion that they were by no means the pleasantest of means—in short, that they were nasty things for both patient and physician, and abandoned their use; but considering Dr. Barnes's high commendation, and with the help of his instrument for application, we shall try them again. That word *pasma*, we suspect, will send more than one of the readers of this book to a medical dictionary, and he will return from his search not perfectly satisfied of the agreement between the author and the lexicographer.

Dr. Barnes does not approve of the nitric acid treatment recently so highly extolled by Dr. Atthill, because of the preliminary dilatation of the cervix necessary, since this is "almost invariably a painful, and sometimes a dangerous proceeding."

We pass now to the forty-first chapter, which is devoted to *peri-metric inflammation*. Peri-metric inflammation corresponds to the peri-uterine inflammation of Courty, Dr. Barnes rejecting the designation peri-uterine because a compound of a Greek and Latin word, a verbal hybrid. The only objection to the term peri-metric that can possibly be suggested is that Dr. Matthews Duncan,¹ adopting it from Virchow, has already used it for inflammation of the pelvic peritoneum.

In peri-metric inflammation Dr. Barnes includes pelvic cellulitis and pelvic peritonitis; he believes that these inflammations generally coexist, and that each "pure and simple is a rare affection." Of course this cuts the Gordian knot, which so many writers on diseases of women, in recent years, have been endeavouring to untie, *to wit*, the diagnosis of inflammation of the pelvic peritoneum from that of the pelvic connective tissue. The

¹ Perimetritis and Parametritis.

thorough investigations of Bernutz,¹ and the differentiation² so clearly set forth by Dr. Thomas, will be materially diminished in value if Dr. Barnes's views prevail. Notwithstanding the very ungracious remark made by Dr. Lauchlan Aitken,³ "Thomas has drawn up a long series of differential points, of which it may be said that in some cases his statements would answer for both complaints, while in many others they might be reversed without impropriety," it is probable nothing better has yet been offered. Dr. Duncan, *op. cit.*, thus refers to Dr. Thomas's efforts:—

"I shall in the mean time only say that we are indebted to Thomas for even attempting the difficult task, and that I shall not attempt to supplant his diagnosis by one of my own."

Is Dr. Barnes right in this fusion made of the two disorders under the title of peri-metric inflammation? He believes that in a great, perhaps the greater proportion of cases, both peritoneum and cellular tissue are inflamed together; but acknowledging either may be inflamed separately, does not give the diagnostic characters of these inflammations. On the other hand, Courty, who makes a similar fusion under the title of *peri-uterine inflammation*, gives the differential diagnosis—mentioning, by the way, most of the very points presented by Thomas in his table, which Dr. Aitken has written so disparagingly of.

But to engage in a discussion of the correctness of the course pursued in common by Courty and Barnes would occupy too much space and time; nevertheless, we fully believe that the investigations of Bernutz have demonstrated much more frequently the occurrence of pelvi-peritonitis than have those of all others the occurrence of pelvi-cellulitis.

However much any of Dr. Barnes's readers may differ as to the propriety of consolidating two maladies under one title—of course the consolidation is made in *form* because the author believes them to exist in *fact*—no one will complain that too many pages—twenty-eight in all, two of which are occupied with the therapeutics—are given to peri-metric inflammation.

On p. 498, Fig. 99, there is an excellent illustration of a tumour arising from peri-metric inflammation, and almost encircling the entire cervix; it is somewhat similar to Fig. 11, p. 210, vol. i. of Bernutz and Goupil's work. We are sorry Dr. Barnes has not given more of such illustrations; they are valuable to any one—invaluable to the physician who has not made himself familiar by actual examination of these most characteristic results of peri-metric inflammation.

Dr. Barnes seems partial to new or little-used expressions or words; thus he gives us instead of the plain word poisoning, empoisonment, which certainly is not French but is obsolete English; instead of blenorrhagic or gonorrhœal peritonitis he has *peritonitis meretricum*, a peritonitis which we hope no moralizing reader will think has any relation to merit, even if he should be puzzled to discover any connection between it and vice on the part of the sufferer.

More than one-half of the brief space devoted to the treatment is occupied with the management of one of the consequences of this inflammation, *abscess*. As to the treatment of the inflammation itself, twelve or twenty leeches to the groins and hypogastrium, fomentations, or a thick.

¹ Clinique Médicale sur les Maladies des Femmes. Paris, 1862.

² Diseases of Women, p. 461 (3d edition).

³ Transactions of Edinburgh Obstetrical Society. Edinburgh, 1872.

linseed-meal poultice, one or two grains of calomel with half a grain of opium every four hours for twenty-four hours, and then every six or eight hours for a day or two longer; bismuth, hydrocyanic acid, creasote, ice, soda-water for the nausea and vomiting; in the more chronic stages where there is no evidence of suppuration or pointing, blisters to the groins and hypogastrium, and iodide of potassium with bark in decoction or tincture internally. Such is Dr. Barnes's treatment in almost as many words for a disease which according to Courty claims a third, according to Aran, counting along therewith metritis both parenchymatous and mucous, two-thirds of uterine maladies. We wish he had told us more, more of what to do, something of what not to do in this disease, which occurs so frequently, has so many different causes, so varying a history, and sometimes such serious consequences.

Where it is possible we believe it better to apply the leeches directly to the cervix, for, as Bernutz has pointed out, a much smaller number will be required, and the blood is abstracted more nearly from the inflamed part. Opium every hour is the direction of Bernutz, "whose therapeutic precepts are essentially practical, and ought to be frequently consulted in giving rules for the treatment of peri-metritis,"—opium thus given until narcotism, and then at longer intervals so as to maintain a slight somnolence. Bernutz does not advise, and Courty positively rejects the internal use of mercury, while Duncan frequently employs this agent but has no great confidence in it. We believe the practice of Bernutz and Courty is the better.

Possibly a much earlier application of blisters than Dr. Barnes advises will be found exceedingly useful in many cases of peri-metric inflammation.

We believe too that a much better combination for these cases than that of calomel and opium, is one of quinia and opium with conium, which according to Bernutz is the special narcotic of the genital organs; for some years the writer has used this combination in the treatment of pelvi-peritonitis, and he has no reason to be dissatisfied with it, and is glad to have the following evidence confirming the value of quinia in peritoneal inflammation. "According to the practice tried by M. Kœberle in peritonitis from ovariectomy ice should not be used; morphia and chloroform inhalation only to calm the acute pain; the true remedy, according to this eminent surgeon, is the sulphate of quinia in a large dose."¹

Peri-metric Hæmatocele is the subject of the forty-seventh chapter. In St. Thomas's Hospital Reports, N. S., vol. i., 1870, Dr. Barnes has collected fifty-three cases of hæmatocele.² A criticism by Dr. Snow Beck upon some of these cases will be found in the fourteenth volume of the London Obstetrical Society's Transactions. This chapter, which contains three illustrations from the Hospital Reports, it seems to us fully and fairly answers those criticisms.

In the course of the chapter Dr. Barnes makes the following statement: Bernutz contends that the extra-peritoneal effusions are thrombi and only result from labour. But in this statement is not Dr. Barnes, partly at least, mistaken? Bernutz expressly says³ *extra-peritoneal*, or as he prefers *sub-peritoneo-pelvic*, hæmatoceles, result, 1st, in the course of ordinary uterine gestation; 2d, in extra-uterine gestation, either tubal or sub-peritoneo-pelvic; 3d, finally, when the uterus is unimpregnated.

¹ Du Reduction de l'Inversion Uterine. By Dr. Weiss. Paris, 1873.

² These were cases of intra-peritoneal effusion; in this chapter he includes extra-peritoneal as well.

³ Nouveau Dictionnaire de Médecine et de Chirurgie Pratiques, v. xvii., article Hæmatocele Uterine.

Uterine hæmatocele is a subject of comparatively recent study, and no writer at least in the English language has contributed so much to our knowledge of it as Dr. Barnes.

In addition to the usually recognized causes of this affection Dr. Marrotte¹ produces three cases to show that it may have its origin in lumbo-sacral neuralgia.

Displacements of the uterus are considered in three chapters containing not a few excellent illustrations.² We must be content with a single extract from one of these chapters, an extract which possibly some physicians will find difficult of digestion if not positively rejected, but which will be acceptable and useful to most.

"Uterine diseases, being surgical rather than medical, want for their successful treatment more rigorous precision in diagnosis than is necessary in the diseases of most other organs. The principles of treatment of most diseases of the brain, breast, lungs, and abdominal viscera are really few. They consist mainly in rest, hygienic management, diet, and a limited use of medicines. I think it may be laid down as an aphorism that most acute diseases not requiring surgical treatment are subdued by time, aided by rest, judicious regimen, salines, and sedatives. Where diagnosis of different diseases results in the same treatment, refinement in diagnosis becomes rather a matter of scientific interest than of concern to the patient. Although it may grate a little on the pure medical ear to hear the case bluntly stated, it is nevertheless true that the rule is very generally acted upon in practice. It is superfluous to point out that this indifferencism in treatment will not do in surgery. It will not do to go on giving salines, alkalies, and sedatives, or placebos to a man who has a stone in the bladder that wants crushing or removing. Nor will it do to trust to salines, sedatives, or tonics where there is a dislocation of the womb that wants rectification."³ (p. 606.)

Inversion of the Uterus is very fully considered as to symptoms, causes, diagnosis, and treatment in Chapter XLVI.

Dr. Barnes prefers amputation of the uterus to abdominal section, and dilatation from within of the constricting portion, as so successfully done by Dr. Thomas.

In speaking of the excruciating pain caused when a ligature is thrown around an inverted uterus, Dr. Barnes states that it is caused by "compression of the included Fallopian tubes."

The following passage from Klob, *op. cit.*, does not seem to indicate such conclusion as probable, though how it does not occur we cannot see :—

"During the enlargement of the pregnant uterus, the oviducts and ovaries are drawn into the lateral margin of the former in such a manner, that the ovaries are almost in contact with the uterus; which circumstance is certainly caused by the uterus taking up the peritoneum of the broad ligament during its distension. If the uterus be inverted, it is evident that the oviducts and ovaries will be found in the newly-formed excavation. But if the inversion has occurred in consequence of a tumour, neither the ovaries nor the fimbriated extremities of the Fallopian tubes have been so approximated to the uterus as

¹ Archives Générales, July, 1873.

² Possibly an exception might be made as to Fig. 107, that looks almost bad enough to be a penal offence.

³ We feel compelled to say a single word as to the expression "subdued by time." *In time*, we can understand, but *by time*, common as the expression is, puzzles us, for in our poor way of thinking time is not a force, and therefore cannot be a factor in the production of any result; *time* has no more to do with subduing disease than the *space* through which light moves has to do with causing vegetable growth.

to be drawn into the inverted cavity. On the contrary, we find in such cases only the commencement of the oviducts are within the excavation. After an inversion of the uterus, succeeding labour, has existed for a length of time, the process of involution of the organ is not arrested, and as this progresses, the above-mentioned excavation diminishes, and the oviducts and ovaries, which in the commencement were in it, resume their original position laterally from its margin."

To Dr. Barnes the profession is indebted for two new modes of practice where other means of reducing inversion have failed; one is *incision of the cervix*, and the other is *continuous elastic pressure*.

Chapter XLVII., *tumours of the uterus*, has numerous illustrations, and is very instructive.

Dr. Barnes states that his experience lends little or no support to the proposition that internal remedies exert any influence in promoting absorption of the hard fibroid tumour. He briefly alludes to the treatment of Hildebrandt, the subcutaneous injection of ergotin. Our own belief is, that this treatment is of the highest value; that in the great majority of cases of uterine fibroids, the hemorrhages will be notably diminished and also the size of the tumours within a month after commencing the hypodermic use of ergot. During the last year we had an opportunity of testing in four cases the value of this therapeutic application, and therefore we speak with some degree of positiveness. Still more, may not the suggestions made by Dr. Guéniot¹ be proved of value? So far as we can judge, by analogy uterine fibroids, in order to be absorbed, must first undergo fatty degeneration. Therefore administer the reputed *steatogenic* agents, such as arsenic, phosphorus, lead, etc. Certainly in one case of uterine fibroids occurring in our practice last year, and suffering from frequently recurring intermittent, for which arsenic was given four months, there has been a notable diminution in the size and in the consistence of the growth, and entire relief from the metrorrhagia.

In speaking of the means for bringing about *enucleation* and *expulsion*, Dr. Barnes remarks, and, familiar as the statement may be to some, it is of the highest importance:—

"The larger tumours, whose texture is continuous with the uterine wall, are not proper subjects of these proceedings. It is from not bearing in mind this fact, which has been so distinctly insisted upon by Rigby and McClintock, that failure and disaster have so often followed surgical proceedings. And since the difficulty of diagnosis between these and the encapsuled tumours is great, the subject is involved in doubt at the very threshold."

The following are the conditions, according to Dr. Barnes, which justify attempting enucleation, avulsion, or other mode of removing large fibroid tumours: 1. Uncontrollable hemorrhages endangering life. 2. Signs of sloughing or decomposition of the tumour, with present or threatening peritonitis or pyæmia. 3. Dangerous pressure upon the bladder and rectum. He also adds: The same conditions threatening life, and removal by the processes above enumerated being precluded, may justify the last resource, that of gastrotomy.

The succeeding chapter upon *polypus of the uterus*, could not be better as to clearness of description, excellence of illustrations, and appropriateness of therapeutics.

Tubercle of the Uterus comes next—a form of disease which is com-

¹ De la Guérison par Résorption des Tumeurs dites Fibreuses de l'Uterus. Paris, 1872.

paratively rare, and of little interest to the practitioner save in point of diagnosis.

Cancer of the Uterus is the subject of the forty-ninth chapter. It is a remarkable fact that woman is much more liable to cancer than man, and that those organs in which the foetus is borne and by which the infant is nourished, the uterus and the breasts—organs consecrated to such high physiological uses, thus ministering to life and the perpetuation of the race—should be especially exposed to the invasion of this disease, which seldom releases its unfortunate victim, seldom takes any retrograde movement, but almost invariably, almost without pause, works on to a fatal issue,—organs of life to others, avenues of death to herself. We may take up the hopeful language of Heurtaux¹ that some facts seem to show cancer is not an absolutely incurable malady, and perhaps one day a specific will be discovered; yet we must confess nothing approximating a specific has been found, and medicine is almost utterly powerless even in staying its progress.

Dr. Barnes, in speaking of diathesis in reference to cancer, remarks, "Some diatheses seem interchangeable or coexistent; as we might, to involve another hypothesis, say that all morbid diatheses are one in their ultimate analysis, and that the development of phthisis in one person, of brain disease in another, and of cancer in a third, is determined by various secondary conditions." He also speaks of our being able to observe in a family frequent examples of various manifestations of the original taint, showing itself as phthisis in one member, cancer in another, and nervous disease in a third. The observations of Dr. Barnes are not quite in accordance with the position taken by M. Burdel,² who asserts, and sustains his assertion by some statistics, that an enormous proportion of the victims of phthisis are born of cancerous parents, or who become cancerous; in other words, cancer in the ascendants produces tubercle in the descendants.

As to *treatment*, Dr. Barnes believes that when the cervix is the seat of disease, "the uterus freely movable, a distinct neck above the diseased portion," and especially if the disease is epitheliomatous or canceroid, it is our duty to amputate: the best method of amputating is by the galvanocautic wire. We must be permitted to say, however, that Sims's method of amputating seems to us preferable, in that it secures immediate healing of the stump. The use of bromine—which Dr. Barnes regards as valuable in checking the growth, as well as a deodorant—that of acetic acid, chloride of zinc, acid nitrate of mercury, arsenical paste, potash, etc., are mentioned. Dr. Routh's experiments with pepsin are spoken of, and Dr. Barnes mentions one case where he has seen it used, in which he was satisfied that the solvent and antiseptic action of the remedy upon the diseased surface was great and beneficial.

In the conclusion of the chapter the following valuable direction is given: "The wise physician will exercise great reserve in enforcing sexual abstinence in the great majority of cases of uterine disease. But in the case of cancer, his injunction should be decided. The direct and remote evils produced by intercourse are so great that regard for the patient's safety leaves no doubt as to the necessity of abstinence. Attacks of hemorrhage, even fatal, have been traced to imprudence in this respect. That the activity of the disease is promoted by it, there can be no doubt. And in

¹ Nouveaux Dictionnaire de Médecine et de Chirurgie Pratiques. Article *Cancer*.

² Archives Générales, May, 1869.

the not improbable event of pregnancy, the risk encountered is vital."¹ We may add that in case pregnancy does happen in these unfortunate patients, abortion or premature labour is very liable to occur, which, upon the whole, may be considered fortunate, since, according to the statistics of Chantreuil,² nearly one-half the mothers die in parturition, or consequent thereon, and more than one-half the children are stillborn.

The fiftieth and fifty-first chapters, which conclude this admirable work, are devoted respectively to *diseases of the vagina*, and of *the vulva*. We shall refer to only two or three points in these chapters. Dr. Barnes states there are four kinds of fistulæ of the genital organs, viz.: 1. Urethro-vaginal or vesico-vaginal. 2. Vesico-uterine. 3. Recto-vaginal. 4. Recto-vesical. Certainly at least two others should be added, viz., *uretero-vaginal*, and *uretero-uterine*. The *treatment* of these lesions is briefly given, briefly in comparison with that we find in "Thomas," still more briefly in comparison with the admirable account given in the last French edition of "Churchill,"³ an account which for fulness and excellence of illustration is unequalled by any work on diseases of females of which we have a knowledge.

On page 744, Dr. Barnes says, "syphilitic sores may occur in any portion of the vaginal canal, but the most frequent locality is the fold or duplicature at the fundus, into which the vaginal portion of the cervix uteri is inserted." (Why not vaginal culs-de-sac instead of the fearful circumlocution?) According to Schwartz,⁴ vaginal chancres are rarer even than uterine, in four cases reported by him where these sores occurred in one or other of the vaginal culs-de-sac, three were consecutive to chancres upon the cervix: he also states that he does not know of a single case of chancre of the middle portion of the vagina. Fournier⁵ speaks of the "astonishing immunity" of the vagina from chancres.

The last topic considered in the chapter on diseases of the vulva is *coccygodynia*, and the late Dr. Nott is justly credited with having preceded Sir James Simpson in the description of this disorder and the surgical means for its cure.

The work set before us is done—done amidst the hurry and often in the weariness of active professional toil—done, for these reasons and for others that might be named, imperfectly, incompletely; but if it helps any one to a better appreciation of the great value, both scientific and practical, of Dr. Barnes's volume, it will not be utterly vain or useless. T. P.

¹ Were we just now disposed to verbal criticisms, we should decidedly object to a vital risk.

² Du Cancer de l'Uterus en point de Vue de la Conception, de la Grossesse et de l'Accouchement. Paris, 1872.

³ Paris, 1874.

⁴ Etude sur les Chancres des Col Uterine. Paris, 1873.

⁵ Leçons sur la Syphilis.